

## State of Connecticut House of Representatives

STATE CAPITOL HARTFORD, CONNECTICUT 06106-1591

REPRESENTATIVE JOSEPH J. TABORSAK 109TH ASSEMBLY DISTRICT

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HOME: 203-744-7888 CAPITOL: (860) 240-8585 E-MAIL: Joseph.Taborsak@cga.ct.gov CHAIRMAN GENERAL LAW COMMITTEE

MEMBER
JUDICIARY COMMITTEE
PUBLIC HEALTH COMMITTEE

March 8, 2012

RE: H.B. 5387: An Act Concerning Health Insurance Claim Forms And The Development Of A Uniform Treatment Authorization Form For Mental Health Services

Dear Chairman Megna, Chairman Crisco, and Honorable Members of the Insurance Committee:

Thank you for raising H.B. 5387, An Act Concerning Health Insurance Claim Forms And The Development Of A Uniform Treatment Authorization Form For Mental Health Services. I am in support of this bill because it should be a fundamental right that a patient's relationship with their doctor is one of confidentiality. I believe this trusted right is even more important in the relationship of a patient and their licensed psychologist, psychiatrist, or other mental health provider.

Currently in our state, this trusted right can be compromised. Before a provider is authorized to provide mental health services to an insured patient, most insurance carriers in the State of Connecticut require the treatment provider to complete an extensive questionnaire regarding the patient. Most, if not all insurance carriers, as a practice, will not approve the provision of mental health services until the questionnaire is completed and returned. These questionnaires vary by the company and most seek irrelevant information of the most sensitive and personal nature. I and others feel strongly that these questionnaires are contrary to state and federal parity laws because they place a burden and obstruction on the provision of mental health services that does not exist in the medical treatment area.

This unfair burden becomes apparent when patients become aware of these over-reaching questionnaires and feel that their privacy is being violated or threatened. This often results in the patient either deciding to not use their insurance and pay for the services out of pocket or to forego treatment altogether. Either result amounts to an obstruction to patients in need of mental health treatment.

The State of Maryland has addressed this issue by adopting a Uniform Treatment Plan Form (see attached) as has the District of Columbia. By mandating a uniform treatment authorization form, all insurance companies must use the same form and are limited to requesting and obtaining only the necessary information. This is a sensible and fair approach to addressing this issue. Such a form should require only relevant and basic information, and should respect parity laws, HIPPA and the therapist-patient relationship.

Thank you for considering this legislation which will provide the safeguards that patients of mental health service providers expect and deserve. Thank you for your time.

Sincerely,

Joe Taborsak

## State of Maryland Uniform Treatment Plan Form (For Purposes of Treatment Authorization)

Carrier or Appropriate Recipient:
Magellan Behavioral Health
Fax: 800-365-5030
- or -

PO Box 4930 Columbia, Maryland 21046-4930

PATIENT INFORMATION	PRACTITIONER INFORMATION
PATIENT'S FIRST NAME PATIENT'S DATE OF BIRTH PRACTITIONER ID# or TAX ID PHONE NUMBER	
MEMBERSHIP NUMBER	PRACTITIONER NAME, ADDRESS & PHONE
AUTHORIZATION NUMBER (If Applicable)	
<u>                                     </u>	
	Date Patient First Seen For This Episode Of Treatment
Have you communicated with the PCP/other relevant health care practitioners about treatment? O Yes O No	
DSM-IV MULTIAXIAL DIAGNOSIS (PLEASE COMPLETE ALL FIVE AXES)	
AXIS I Dx Code	Dx Code
AXIS II Dx Code	
	ndition that is potentially relevant to the understanding or management of
AXIS III Does the patient have a current general medical condition that is potentiany relevant to the understanding of transgement of the condition(s) noted in Axis I or II? O No O Yes	
AXIS IV Severity of current psychosocial stressors	O Moderate O Severe
O None O Mild	
AXIS V: GAP Sture Ingress reast reast	
Current Medications (if not applicable, no response is required)	
O Anti-psychotic O Anti-anxiety O Anti-depressant	O Psycho-stimulant O Injectables
O Hypnotic O Non-psychotropic O Mood stabilizer/	
Symptoms  Please rate the patient's current status on these symptoms, if applicable. If not applicable, no response is required.	
Ideation Plan Prior None Present Absent	
Attempt	
Suicidal ideation O O O	
Homicidal ideation O O C	Substance use problems
Authorization Request Details	
Complete this section only if a second CPT is needed.	
CPT Number	CPT Number
Code of Units	Code Of Units Of Units
	Frequency (once a week, etc.):
Frequency (once a week, etc.):	riequency (once a week, etc.).
Requested Start Date of Authorization:/	Requested Start Date of Authorization:
Signature of practitioner:	
My signature attests that I have a current valid license in the state to provide the requested services.	